DOCUMENT RESUME

ED 315 805 CS 506 978

AUTHOR Lippard, Paula V.
TITLE Communicative Imagery: A Qualitative Investigation of the Effectiveness of a Behavior Change Strategy on the Chronically Mentally Ill.
PUB DATE Apr 88
NOTE 25p.; Paper presented at the Annual Meeting of the Eastern Communication Association (79th, Baltimore, MD, April 27-May 1, 1988).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Behavioral Objectives; *Behavior Change; *Behavior Disorders; Behavior Patterns; *Change Strategies; Communication Research; Locus of Control; Mental Disorders; *Mental Health; *Self Efficacy; Visualization
IDENTIFIERS Health Communication; Rotter Internal External Locus of Control Scale; *Self Defeating Behavior; Small Group Communication

ABSTRACT

An exploratory study investigated the success of a small group behavior change program in eliminating self-defeating behavior (SDB) in outpatients with chronic mental illness. Four of the six subjects were outpatients at the local mental health center but were currently not exhibiting psychotic behavior. The remaining two subjects were student interns at the mental health center who were working toward master's degrees in social work. The program utilized a variety of methods of behavior change within the vehicle of the small group. All subjects completed the following instruments: (1) Rotter's Internal-External Locus of Control Scale; (2) a specific behavior locus of control scale; and (3) an efficacy expectation scale. All subjects attended 8 weekly sessions and participated in 12 activities which were carried out each week. Follow-up scores indicated that the program was partially effective. One subject succeeded in eliminating and replacing her SDB. Three subjects reported some positive change in their SDB's at the 3-week follow-up. One subject reported an increase in frequency of her SDB. Follow-up scores did not necessarily coincide with subsequent behavior. The data of test scores, subject participation, and follow-up were examined qualitatively in the manner of a set of case studies; results were not compared statistically. (One table of data is included and fourteen references are attached. Three appendixes include: Specific Behavior Locus of Control Scale, Efficacy Expectation Scale, and Follow-up Scale on Self-Defeating Behavior Workshop.) (MG)

**********
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
**********

ED315805

# Communicative Imagery
## A Qualitive Investigation of the Effectiveness of a Behavior Change Strategy on the Chronically Mentally Ill

Paula V. Lippard
Department of Speech Communication
Old Dominion University

Eastern Communication Association
Convention 1988
Applied Communication Division:
Competitive Papers

CS506978

BEST COPY AVAILABLE



"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Paula V. Lippard
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)"

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Changes in laws governing the institutionalization of the mentally ill and in preferred treatment have made increasing numbers of chronically disturbed clients the responsibility of local mental health centers. The mainstreaming of these clients into community life requires the development of rehabilitation methods beyond traditional psychotherapy, since such therapy is impractical in use of professional staff time and in producing significant improvement in chronic patients. In addition, many mental health workers are not trained in clinical psychology or psychiatry, but bring a variety of other skills to outpatient treatment. These skills can be utilized in structured group programs aimed at improving such areas as socialization, self-expression, communication, health habits, job skills, and creativity, as well as providing therapeutic insight and catharsis. However, little research has been done to examine the effectiveness of group programs on behaviour change in chronic patients.

A variety of group programs aimed at behavior change are widely used in mental health centers and other community settings. They incorporate a number of attitude and behavior change strategies including: public disclosure of and public commitment to change a particular attitude or behavior; use of coping models; role-play activities; guided imagery; emotional catharsis; cognitive explor-

ation of origins and maintenance of the behavior problem; and enactment of replacement behaviors with feedback.

Research in attitude change and persuasion indicates that persons who make a public commitment to an attitudinal position are less susceptible to opposing arguments and more convinced of their position's validity (King, 1976; Zimbardo et al., 1977). Studies in this area also conclude that role-playing opposing positions to one's own functions as an effective means of self-persuasion (Zimbardo, 1977). Jourard's work in self-disclosure (1964) reveals that disclosure of personal information and feelings creates trust between persons and encourages further disclosure. The cycle contributes to empathy and identification between persons, a state necessary for vicarious modeling.

Research in desensitization of phobic and anxiety responses and in acquisition of motor and interpersonal skills (Kazdin, 1974; Mahoney, 1974; Bandura et al., 1969) indicates that visualization of new behaviors functions as an effective method of behavior change. Bandura (1977) suggests that vicarious participation through models and through symbolic experience is more effective. He concludes, however, that the best and longest lasting behaviour changes result from enactment of new behaviors in both practice and natural settings with corrective feedback.

Bandura's research (1977) also indicates that a subject's "efficacy expectation" is one of the best indicators of his or her potential success or failure in a change process. Efficacy expectation is defined as the conviction that one can successfully

execute behavior required to produce a desired outcome.

Theory in Gestalt therapy emphasizes that all behavior is a gestalt expression of the organism, manifesting on the symbolic, motor, emotional, and interpersonal levels. If all levels are engaged in the change process, greater behavior change can be effected (Fagan and Shepard, 1970). Therefore, symbolic participation, emotional arousal, and physical and interpersonal enactment combined is most effective in behavior change programs.

In addition, studies in communication, social learning theory, and cognitive psychology reveal that humans are not passive receivers of environmental stimuli which cause behavioral responses. On the contrary, they bring innate and learned patterns of selecting, interpreting and responding to external stimuli to all new contexts. Wilmot (1977) states that the two most important perceptual interpretations occurring in communication contexts are (1) the imposition of structure, and (2) the attribution of causality and responsibility. As a result, how the individual interprets, thus experiences, a treatment situation may be quite different from another's interpretation and experience. Therefore, in assessing the effects of a behavior change program on the individual subjects, it is necessary to determine what pertinent predispositions they bring to the treatment.

The purpose of this study was to investigate the success of a small group behavior change program utilizing the above cited influence strategies in eliminating self-defeating behavior in outpatients with chronic mental illness.

## Methodology

### Description of Subjects

All subjects in the program were volunteers. Four of the six subjects were outpatients at the local mental health center who had been diagnosed as schizophrenic; had suffered psychotic episodes characterized by hallucinations and thought disorders; had made suicide attempts or gestures; had used medication to control depression or anxiety; and who were currently not exhibiting psychotic behavior. All four patients were in their twenties, and were above average in intelligence.

The remaining two subjects were student-interns at the mental health center. Both were females, in their thirties, divorced with children, and working toward master's degrees in social work.

Individual characteristics of all six subjects may have contributed to their experience of and response to the treatment; therefore, these are given below. Subject A is physically handicapped with cerebral palsy; she had also been the victim of child abuse. Subject B had a lengthy history of suicide gestures and attempts; she was the youngest of the group. She had also worked in previous groups with the researcher/leader. Subject C was the only male of the group. He had been married and had completed one year of graduate work. Subject D also had a diagnosis of disassociative hysteria (multiple personalities). She had

been the victim of severe child abuse and incest. She is currently married with one child and is employed. She is a private client of the researcher. Subject E, a volunteer, had experienced emotional problems and came to therapy following her divorce. Subject F was also a volunteer with no history of therapy.

## Program Design

The program utilized a variety of methods of behavior change within the vehicle of the small group. These included:

(1) public commitment to change the self-defeating behavior;

(2) public disclosure of self-defeating behavior;

(3) cognitive awareness of and insight into why the behavior was begun and how it is maintained;

(4) arousal of emotions associated with the need to engage in the behavior;

(5) vicarious experience of others' change processes (coping models) and of one's own fantasized change processes;

(6) symbolic visualization of new behaviors;

(7) role-playing of new behaviors;

(8) enactment of new behaviors in natural settings;

(9) feedback on the enactment.

There was no attempt to control for the effect of a specific method, rether the researcher assumed that a single method would have different effects on different subjects. In addition, it was assumed that certain methods worked best in combination.

All subjects completed the following instruments:

(1) Rotter's Internal-External Locus of Control Scale;

(2) A specific behavior locus of control scale; (see Appendix A)

(3) An efficacy expectation scale. (see Appendix B)

The latter two scales were created by the researcher. Locus of control measures were chosen, as research suggests that "congruence between locus of control expectancies and the structure of the therapeutic endeavor appears to lead to the most pervasive changes" (Strickland, 1978, p. 1203). Apparently, "internals," that is, those who see themselves as primary agents of control, respond more positively to nondirective approaches with minimal structure; while "externals," those who see themselves as victimized by external forces, respond more positively to structured approaches (Strickland, 1978). In addition, locus of control is seen as a generalized measure of individual expectations.

## Treatment

All subjects attended eight weekly one and one-half hour sessions. During these sessions, the following activities were carried out:

1) brief lecture on principles of behavior change and definition of "self-defeating behavior" (SDB);
2) participant selection of SDB to be focused on during the program (Task 1);
3) public ownership of responsibility for the SDB and public commitment to change it (Task 2);

4) written preparation of lists of at least six ways in which each participant maintained and at least six ways in which each participant justified to self and others the SDB--lists were voluntarily shared with other participants (Task 3);

5) written preparation of a one page narrative describing self engaging in the SDB--narratives were voluntarily shared with other participants (Task 4);

6) written preparation of at least six costs each participant experienced for engaging in the SDB--shared voluntarily with other participants (Task 5);

7) visualizations of the fear which lay behind giving up the SDB with leader-guided interaction with the image (Task 6);

8) public disclosure of the need behind the SDB (Task 7);

9) selection of an alternative behavior for meeting the above stated need (Task 8);

10) role-playing of a more appropriate behavior for meeting this need (Task 9);

11) practice of the new behavior in a natural setting with report back to the group (Task 10);

12) completion of follow-up scale three weeks after the final session indicating present state of the SDB (Task 11) (see Appendix C).

## Analysis of Data

This study was exploratory; the researcher was not concerned

with generalizing or predicting from the results. Therefore, the data of test scores, subject participation, and follow-up reporting were examined qualitatively in the manner of a set of case studies. Results were compared, but not statistically.

## Discussion

Each subject's test scores, participation, and follow-up scores are presented in Table 1 Subject Profiles and are discussed in detail below. [insert Table 1 here]

### Subject A

Ann's chosen behavior was thumbsucking. This behavior was part of a repertoire of behaviors, which included whining, crying, curling into a ball or turning her body away, refusing to speak, and finally throwing a temper tantrum. She scored in the middle on the Rotter Scale. Her Specific Behavior Locus of Control scores and Efficacy Expectation scores were high, indicating a strong sense of personal responsibility in changing her SDB. She attended seven sessions and completed ten of the eleven tasks. She reported a decrease in the frequency of her SDB and less need satisfaction in doing it at the three week follow-up.

Ann sought an alternative behavior in her visualization, role-played this alternative, and practiced it in a natural setting. She was not able to visualize herself doing an alternative behavior, but she emerged from the imaging exercise aware that her SDB reflected an intense need to depend on her mother, and

a desire for physical safety and psychological security in the world. She also generated in the image a powerful personal symbol for continuing change--the figure of Helen Keller, another multiple handicapped individual who achieved self-sufficiency and independence in society.

After the completion of the program, the mental health center staff reported noticeable improvement in Ann's independent behavior and cooperative group participation. Shortly thereafter, she moved from an intensive treatment residential center to living in an apartment on her own.

Subject B

Betty's chosen behavior was her suicide gestures. These included wrist-slashing and overdosing following periods of intense depression. She scored in the midrange on the Rotter Scale. Her Specific Behavior Locus of Control score was very low, and her Efficacy Expectations were low, indicating a minimal sense of personal responsibility in changing the SDB. She was the only subject who attended all eight sessions, was consistently punctual, and attempted all tasks. She reported a decrease in the frequency and need satisfaction of her SDB at the three week follow-up.

Betty was able to visualize an early source of her SDB in her father's abusive anger toward her. However, she became very "stuck" in the image when she needed to confront the voice of her dead brother who asked her to join him in death. She could not even attempt this step. Similarly, although she attempted

both in the role-play and in a natural situation to express her anger at others in a legitimate manner, she was unable to do so. Within a month after the behavior change program, Betty began intensifying her self-destructive behaviors and has continued. However, they are less life-threatening and more self-mutilating, i.e., slashing her face and limbs with razors.

Subject C

Carl's chosen behavior was oversleeping, which was causing him to arrive late to work, miss work, and lose his jobs. This behavior was a recent problem, not a long-term one. Unfortunately, Carl attended only the first session. However, he did not complete the Rotter Scale. His Behavior Locus of Control score and Efficacy Expectation score were in the midrange, indicating a partial sense of personal responsibility in changing his SDB. Carl's excuse for leaving the group was having to be at work during the time period. However, within two weeks after the group had begun, Carl lost his job.

Subject D

Diana's chosen SDB was forgetfulness. She constantly "spaced out" small tasks or steps in sequential activity.

She scored highest on the Rotter Scale, indicating high externality. Her Specific Behavior Locus of Control score was very low and her Efficacy Expectation was low also, indicating a minimal sense of personal responsibility in changing her SDB. She attended seven of the eight sessions, and completed eight of the eleven tasks. She reported an increase in her SDB at

the three week follow-up.

Like Ann and Betty, Diana entered deeply into her imaging experience. She tied her minor forgetfulness into the major compartmentalization of her consciousness into the multiple personalities she had created to escape the full impact of her physical and psychological pain in childhood. She, of all the outpatients, attempted an alternative behavior in the image, almost allowing the leader to "enter her secret fantasy room with her" in the image exercise. However, she would not role play or enact an alternative behavior in a natural situation.

Diana continued to complain of increased forgetfulness in her private sessions with the researcher. However, about two months after the program, she reported that her remaining personalities had receded. She no longer "blacked out and lost control to another personality." And she began to feel emotions which once were only experienced by the other personalities.

Subject E

Eve's chosen behavior was procrastination, particularly in reaction to her schoolwork. She reported becoming "immobilized" and unable to work for periods of time. She scored very low on the Rotter Scale, indicating high internality. Her Specific Behavior Locus of Control score and Efficacy Expectations were very high, indicating a strong sense of personal responsibility in changing the SDB. She attended six of the eight sessions and completed five of the eleven tasks. She reported no change in the frequency of her SDB, but less need satisfaction. Although

she participated in the visualization exercise, she was unable to sustain an image. She did not choose an alternative behavior, and therefore could not role-play or enact it.

She continues to report periods of procrastination and an increase in "immobilization."

Subject F

Fran's chosen behavior was failure to contribute in group situations, particularly college classes. She scored low on the Rotter Scale, indicating high internality. Her Specific Behavior Locus of Control score and Efficacy Expectation score were very high, indicating a strong sense of personal responsibility and personal efficacy in changing the SDB. She attended six of the eight sessions, completed eight of the eleven tasks, and reported that she had eliminated her SDB at the three week follow-up. Her visualization experience was highly symbolic, that is, it did not reveal realistic links to specific experiences or problems in her life. However, she was able to confront a threatening situation on the symbolic level, and was the only subject to emerge pleased and happy from her image.

## Conclusions

Examining the follow-up scores alone indicates that the program was partially effective. One subject (a volunteer) succeeded in eliminating and replacing her SDB. Three subjects (two outpatients, one volunteer) reported some positive change in their SDB's at the three-week follow-up. One subject (an

outpatient) reported an increase in frequency of her SDB.

Test scores were not generally predictive of positive behavioral change with the exceptions of the two subjects who received the highest and lowest scores on most of the measures. Subject F, a volunteer and the only subject to eliminate and replace her SDB, received scores indicating high overall internality and high efficacy expectations.

In contrast, Subject D, an outpatient who reported an increase in her SDB at the three-week follow-up, received scores indicating high externality on both locus of control measures. In addition, D's Efficacy Expectation score was the lowest of all six subjects.

Degree of participation, as indicated by attendance and tasks completed, was not predictive of subject success. Subjects varied in their task completions, but these variations did not correlate with follow-up reports. Both Subject D, who reported in increase in her SDB, and Subject F, who reported elimination, completed eight of the eleven tasks.

However, it is also important to examine behavior beyond the three-week follow-up period and beyond the reported change at that time. As stated earlier, follow-up scores did not necessarily coincide with subsequent behavior. The most dramatic example is that of Subject B, who reported a decrease in frequency and need satisfaction of her SDB, but later increased and intensified her suicide gestures and self-mutilations. In contrast, Subject D, who reported the only increase in her SDB, began to progress very favorably in therapy in several areas. Subject A, who

reported a decrease in frequency, also improved in overall independent bahavior and self-sufficiency according to later staff reports. Subject E, who reported no decrease in frequency, but one in need satisfaction, seems to have maintained at this plateau.

These subsequent findings point to a factor not pinpointed in the original design. This study, like many other behavior change studies, sought to measure the effect of a specific treatment program on a specific behavior in individuals with differing characteristics. The primary dependent variable was change in the subjects' self-defeating behaviors. Maintenance or increase in the SDB would indicate failure of the treatment program, a decrease in the SDB would indicate success for a given subject.

However, it was apparent that the specific behavior chosen by a subject was symptomatic of a behavioral "gestalt." Subjects A, D, and B present the clearest examples of such gestalts.

Subject A's thumbsucking was not only part of a repertoire of behaviors, but, as her image revealed, it symbolically revealed her intense fear of adult independence in an apparently unsafe world and her desire to retain the safer dependency of childhood. In facing this fear in her visualization image and providing herself with a personal "talisman" in the image of Helen Keller, A began to modify her behavioral gestalt and move toward greater independence. Although she continued to thumbsuck, she changed larger behavioral responses connected with this gestalt, such as moving out of a dependent environment into an apartment of

her own.

Subject D's forgetfulness was also a symptom of a much more comprehensive behavioral gestalt, the largest symptom of which was her multiple personalities. D confronted her choice to "shut out" an unsafe world in her image, and teetered on the brink of allowing the researcher into her safe fantasy room. The multiple personalities had been a means to "forget" and blank out parts of her existence. Although she reported an increase in the little daily forgetfulness, D's personalities began to fade away. Currently, she is functioning in therapy as a single personality with access to the feelings formerly experienced only by other "selves."

Subject B's suicidal gestures represented the essence of her desire for self-destruction. Her inability to see her dead brother's voice in her image as an introject rather than an external command prevented her from confronting the gestalt. However, some modifications have taken place as her gestures became less life-threatening.

These examples emphasize three points. First, to measure change in a specific symptomatic behavior will not necessarily reveal a treatment's effect on a deeper behavioral gestalt. Second, the effective treatment of <u>any</u> symptomatic behavior can lead to significant changes in the behavioral gestalt from which it stems. Thus, it is not necessary to "discover the real problem" initially, but like a tapestry thread, a simple symptom will weave through and reveal the whole pattern. Third,

an important route to the behavioral gestalt behind any symptomatic behavior is through the use of images. All images, by their nature, are gestalts; they reveal a whole analogy or metaphor, often explaining the symbolic nature of a puzzling symptom. If the image exercise was most predictive of changes in the behavioral gestalt, rather than merely in the specific SDB, the following predictions can be made. Subject F, who was the only subject to complete her visualization satisfactorily, should have experienced the greatest degree of change. Subjects A and D, who failed to complete their images, but did face the fears, should have experienced the next degree of behavior change. Subject B, who refused to confront a key aspect of her image, should have experienced negative behavior change because of an intensifying of the fear. Finally, Subject E, who was unable to maintain an image, should have experienced no behavior change.

These predictions are somewhat borne out. Subject F was the only one to eliminate and replace her SDB. No other behavioral measure is available for her, however. Both Subjects A and D have manifested overall positive changes in their behavioral gestalts, A in independent bahavior, D in personality integration. B has increased self-destructive behaviors. E reports minimal change in her self-defeating behavior.

In addition, although use of primary process cognition activities are often contraindicated for the psychotic personality, results of this program suggest that they can be used in a controlled environment with positive effect.

These conclusions, then, expand our understanding of Bandura's work on self-efficacy. He has concluded that a sense of self-efficacy in one area generalizes to other areas of behavior, strengthening the self-concept overall. One may suggest that the generalization of efficacy occurs because the symptomatic behavior change actually represents a change in a comprehensive behavioral gestalt which affects self-efficacy in a number of areas.

BIBLIOGRAPHY

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. Psychological Review, 84, 2.

Bandura, A., Jeffery, R.W., and Gajdos, E. (1975). Generalizing change through participant modeling with self-directed mastery. Behavior Research and Therapy, 13.

Bandura, A., Blanchard, E.B., and Ritter, B. (1969). The relative efficacy of desensitization and modeling approaches for inducing behavioral, affective and attitudinal changes. Journal of Personality and Social Psychology, 13.

Fagen and Shephard, Editors. (1970). Gestalt Therapy Now. New York: Harper and Colophon Books.

Green, Elmer. Beyond Biofeedback.

Jourard, Sidney. (1964). The Transparent Self. New York: D. Van Nostrand.

Kazdin, A.E. (1974). Covert modeling, imagery assessment, and assertive behavior. Journal of Abnormal Psychology, 83.

King, Stephen. (1976). Communication and Social Change. Reading, MA: Addison-Wesley.

Mahoney, M.J., and Thoresen, C.E. (1974). Self-Control: Power to the Person. Monterey, Calif.: Brooks/Cole.

Marlowe, David, and Gergen, Kenneth J. (1969). Personality and social interaction. In Gardner Lindzey and Elliot Aronson (eds.), The Handbook of Social Psychology, Vol. III: The Individual in a Social Context. Reading, MA: Addison-Wesley.

Parry, John. (1967). The Psychology of Human Communication. New York: American Elsevier.

Strickland, Bonnie R. (1978). Internal-external expectancies and health-relted behaviors. Journal of Consulting and Clinical Psychology, 46.

Wilmot, William. (1979). Dyadic Communication, 2nd Ed. Reading, MA: Addison-Wesley.

Zimbardo, Phillip G., Ebbesen, Ebbe B., and Malach, Christina. (1977). Influencing Attitudes and Changing Behavior. Reading, MA: Addison-Wesley.

APPENDIX A SPECIFIC BEHAVIOR LOCUS OF CONTROL SCALE

Using the scale below, rate the following list of items in terms of "How important is this item to my success in eliminating my self-defeating behavior".

5 - vitally important 4 - important 3- somewhat important
2 - not so important 1 - totally unimportant

____1. How willing I am to share with other group members during sessions. (+4)

____2. How creative I am in coming up with alternative behaviors to my SDB. (+3)

____3. How much personal attention I get during the sessions. (-5)

____4. How skillful the leader is. (-2)

____5. Whether I complete each written exercise. (+6)

____6. How willing I am to try out the alternative behavior in another situation. (+8)

____7. Whether or not I persist in avoidance behaviors during the sessions (+5)

____8. Whether or not other group members like me. (-5)

____9. How willing I am to role-play an alternative behavior. (+4)

___10. Whether or not I show up for each session. (+1)

___11. Whether or not others quit their SDB. (-5)

___12. My committment to change. (+8)

___13. The support of other group members in changing. (-3)

___14. How things go in my life in general during the program: (-4)

___15. How long I have done my SDB. (-5)

___16. The fact that I tried to stop before and failed. (-6)

___17. How often I use the SDB. (-5)

___18. Whether or not I like the leader.. (-3)

___19. Whether or not I like group members. (-7)

___20. How willing I am to visualize the need behind the SDB. (-4)

___21. How willing I am to accept the need behind the SDB. (-4)

Now go back and choose the <u>5 most important</u> variables for you and rank them below in order to importance.

APPENDIX B EFFICACY EXPECTATION SCALE

Below are a list of tasks which are part of the program "The Elimination of Self-Defeating Behavior". Using the scale given below rate each task in the blank provided.

5- absolutely 4-very likely 3-possibly 2-unlikely 1-not at all

_____1. I will attend all group meetings.

_____2. I will come on time.

_____3. I will not leave early.

_____4. I will choose a specific behavior to work on.

_____5. I will state to other group members that I take resonsibility for "doing" that behavior.

_____6. I will describe examples of past instances where I have chosen to do that behavior to other group members.

_____7. I will state to other group members that I am now choosing to stop that behavior and will seek a positive alternative.

_____8. I will list in writing a number of ways that I maintain that behavior in spite of my awareness that it is self-defeating.

_____9. I will share aspects of that list with other group members.

____10. I will write a narrative of myself - first person, present tense - engaging in that behavior.

____11. I will share a summary of that narrative with group members.

____12. I will write a list of justifications I tell others and myself in order to continue the benvior.

____13. I will share aspects of that list with group members.

____14. I will write a list of costs which I payfor continuing in the behavior.

____15. I will share this list with other group members.

____16. I will be able to visualize myself engaging in an alternative, more positive behavior.

____17. I will be able to role play this alternative behavior with other group members in a simulated situation.

____18. I will be able to practice this alternative behavior in another group situation.

____19. I will record the experience of this practice.

____20. I will share this memory with group members.

____21. I will be able to visualize the need which lies behind my SDB.

____22. I will be able to accept this need in myself as legitimate.

____23. I will be able to recognize and stop any of the avoidance behaviors listed below during group sessions.

APPENDIX C FOLLOW-UP SCALE ON SELF-DEFEATING BEHAVIOR WORKSHOP

Check one of the following statements which best describes you.

_____ 1. I am no longer using my SDB and have been able to satisfy the need which that behavior met with a more positive alternative behavior.

_____ 2. I am no longer using my SDB but have not been able to satisfy the need which that behavior met with a more positive alternative behavior.

_____ 3. I have experienced a decrease in the frequency of my SDB and have experimented with using a more positive alternative behavior.

_____ 4. I have experienced a decrease in the frquency of my SDB and a decrease in need satisfaction when using it.

_____ 5. I have experienced a decrease in need satisfaction when using my SDB, but no change in the frequency of use.

_____ 6. I have experienced no change in need satisfaction or frequency of use of my SDB.

_____ 7. I have experienced an increase in need satisfaction when using my SDB, but no increase of frequency of use.

_____ 8. I have experienced an increase of frequency of use of my SDB.

_____ 9. I have experienced an increase in both need satisfaction and frequency of use of my SDB.

If you would like to add any additional or qualifying material to the statement checked above, please write it below:

## SUBJECT PROFILES

| Subject | Rotter Scale Score Range--0-30 | Specific Behavior Scale Score Range--0-35 | Efficacy Expectation Scale Score Range--0-110 | Absences Range-0-8 | Tasks Completed Range--0-11 |
|---|---|---|---|---|---|
| A | 13 | 24 | 102 | 1 | 10 |
| B | 14 | 4 | 91 | 0 | 11 |
| C | -- | 24 | 94 | 7 | 0 |
| D | 21 | 11 | 89 | 1 | 8 |
| E | 5 | 29 | 103 | 2 | 5 |
| F | 3 | 32 | 105 | 2 | 8 |

Table 1